



## Anamnesis Male/Father

The completion of this questionnaire helps to prepare the consultation and thus facilitates the conveyance of as much information as possible in this conversation. All information is given voluntarily. **Naturally, all information is subject to medical confidentiality and data protection and will be treated strictly confidential.** If you have any questions or problems when filling in this questionnaire, please contact us on telephone (0316) 385-73800.

First- and surname: \_\_\_\_\_ Title: \_\_\_\_\_

Street: \_\_\_\_\_ Postal code: \_\_\_\_\_ Place: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Name of birth: \_\_\_\_\_

single/  married/  divorced /  widowed since: \_\_\_\_\_ Social security no.

Health insurance: \_\_\_\_\_ (e.g. GKK Stmk, BKK Zeltweg, Gew. Wirt., BVA, Bauern ...)

Actual occupation: \_\_\_\_\_ daytime telephone: \_\_\_\_\_ / \_\_\_\_\_  
area code telephone number

1. **Reason for request:** \_\_\_\_\_

2. Please give the following information on your **wife/partner**:  
Are you related to your wife/partner? If yes, how? \_\_\_\_\_

3. Please answer the following questions concerning your own medical history  
**(personal anamnesis):**  
Previous diseases, operations, hospital stays, x-ray examinations, medication,  
etc.: \_\_\_\_\_

Work-related pollution: \_\_\_\_\_ Nicotine consumption: \_\_\_\_\_

Alcohol intake: \_\_\_\_\_ Further desire to have children? \_\_\_\_\_

Further supplements: \_\_\_\_\_

4. The following questions refer to medical problems within your family (**family history**):  
Do any specific diseases accumulate within your family? Which and who?

- 4a. If your wife/partner has filled in the respective form and if it already contains information on your **children**, please skip this point. Otherwise, or if you have children with another partner, please give the following information:

	Child 1	Child 2	Child 3	Child 4
First- and surname:				
Date of birth:				

If one or more of these children have/have had any medical problems (developmental retardation, hospital stays, etc.), please give the following additional information:

	Child 1	Child 2	Child 3	Child 4
<b>Pregnancy:</b>				
Complications:				
Medication? When: Which:				
X-ray examinations?				
Results from ultrasound scans?				
Did you have rhesus incompatibility?				
<b>Birth:</b>				
Place of birth:				
Hospital:				
Spontaneous delivery or caesarean section?				
Duration of labour:				
Birth weight/-length:				
Complications:				
Head circumference/APGAR (see Mutter-Kind-Pass)				
<b>Congenital diseases/ alterations:</b>				
Which?				
Treated where?				
<b>Development:</b>				
Sucking weakness:				
Failure to thrive:				
Steady holding of head:				
First teeth:				
Sitting:				

Walking:				
Speaking:				
Other problems (e.g. Epileptic seizures, etc.):				
Previous diseases:				
Hospital stays:				
Medication:				
School attendance:				
Occupation:				
<b>If deceased:</b>				
When:				
Where:				
Cause of death:				

4b. The following information on your **parents** is required:

	Mother	Father
First- and surname:		
Birth name:		
Date of birth:		
Occupation:		
Particular diseases:		
If deceased: when: Cause of death:		
Where there miscarriages or stillbirths?		

4c. How many siblings/half-siblings do you have: \_\_\_\_\_

Please give the following information on your siblings (if more than 4 siblings, please attach separate sheet):

	1.	2.	3.	4.
First- and surname:				
Date of birth:				
S. or HSM. or HSP. *				
Particular diseases:				
Where there miscarriages or stillbirths?				
If daughters: Number and age:				

Diseases:				
If sons: Number and age: Diseases:				

\* S=siblings, HSM = half-siblings maternal, HSP = Halbgeschwister paternal

4d. Is there any health-related information concerning your grandparents?

\_\_\_\_\_

5. Name and address of your

<b>Family doctor</b>	<b>Medical specialist (incl. discipline)</b>

6. Date: \_\_\_\_\_ Signature: \_\_\_\_\_